ventriculi sinistra as near centrally as possible, after which the vessels are divided between the ligatures.

The arteria and vena coronaria ventriculi sinistra divide into a number of branches, which are distributed to both the anterior and posterior surfaces of the left portion of the stomach, which they grasp as a clamp and add considerably to the strength of its attachment to the posterior portion of the abdominal wall. The vessels will be most easily reached high up, if at the time of applying the ligatures the assistant turns the cardia on the axis of the œsophagus toward the left.

After cutting through the bloodvessels the cardia becomes more movable. An assistant passes the flexed index finger of the left hand—with the palmar surface forward—behind and around the stomach as far as possible above the fundus, and on the tip of his finger the thin layers of tissue which are reflected from the left side of the stomach to the posterior abdominal wall are divided.

3. Isolation of the lower part of the œsophagus. The serous covering is divided with scissors around the cardia; the anterior portion of the foramen œsophageum is freed from the diaphragm; every visible vessel (mostly branches of the phrenic artery) is caught; the cardia is drawn downward and isolated.

While isolating the œsophagus one must remember that an incautious cut might easily open the pleural cavity. The œsophagus and pleuræ are so closely applied to each other that when the cardia is drawn downward it is difficult to distinguish between the two. If the tension be relaxed, however, it will be observed that in the respiratory movements the pleura is inflated sail-like, which guides the operator to the dividing line.

If this point is accurately found, the œsophagus may be easily isolated with two anatomical forceps; only at the posterior surface will the scissors be required to assist in the dissection.

4. Excision of the cardia, union of the cut surfaces. Broad strips of gauze are drawn under the cardia to prevent infection of the peritoneal cavity at the time of dividing the intestinal canal. For the same reason large pieces of gauze should be placed under the borders of the abdominal wound to close off the abdominal cavity. The points are selected at which the alimentary canal must be divided above and below the new growth, but before making the incision the œsophagus is to be stitched to the stomach on the posterior half by a double row of sutures. Then follows the excision of the cardia from the stomach, preferably not by a single cut, as a large surface would thus be produced which could scarcely be securely closed during the suturing. The incision is begun on the left half, and carried around, portion by portion, the edges of the stomach being united as fast as the incision is made. When the stomach is entirely cut through its lumen is occluded by the fingers of an assistant, and the division of the œsophagus made near the point that has been sewn to the stomach. The œsophagus is divided, a portion at a time, and united to the stomach wound as it is cut; it is important thus to retain hold of the upper cut surface until the stomach and œsophagus are firmly united. Without this precaution the divided end of the œsophagus disappears in the foramen œsophageum, and suture is then scarcely possible. The author does not pass the sutures parallel with the

long axis of the œsophagus, but obliquely, as a better hold is thus secured. The suture having been completed, the gauze is removed and the abdominal wound closed.

PERINEAL DISPLACEMENT OF THE TESTICLE.

POLLARD reports (*The Lancet*, 1894, vol. ii., No. 2) a case of perineal displacement of the testicle in a child one month old, upon which he performed an operation for restoring the organ to its normal position. The right testicle in this case occupied a position in the posterior part of the fold between the scrotum and thigh. The corresponding half of the scrotum was flattened and badly developed. The testicle was not very movable.

The operation was performed as follows: An incision was made from just below the external ring to the lower end of the testicle, which with the spermatic cord and their coverings were raised from their bed, as in the operation of castration, and turned upward as far as the external abdominal ring. An incision was next made into the lower part of the scrotum, and a sinus forceps was thrust from this wound through the cellular tissue to the upper part of the first incision, near the external ring, and its blades separated to prepare a track for the artificial descent of the testicle. Through this track the testicle was pushed down to the bed prepared for it at the bottom of the scrotum. Both wounds were closed by sutures. The infant was discharged on the tenth day after operation.

The boy was seen again seven and one-half years after the operation. The right testicle was found to occupy its natural position and to be as large as its fellow. It also responded equally with the left one to the usual method of producing the cremasteric reflex.

So far as the writer knows, this method has not been adopted before. An objection to postponing this operation until the second year of life or later is that in the malposition the testicle is apt to be arrested in its development.

A RARE FORM OF TUMOR OF THE PAROTID.

MANDOWSKY reports the following rare case in the *Aerztlichen Praktiker*, 1894, No. 32. A woman aged twenty-three years consulted Prof. Schüller on account of a hard swelling under the lobe of the right ear in the parotoid region and on the corresponding side of the neck. Nine years previously an enlarged gland appeared in this situation and was removed. A swelling soon recurred, which increased very slowly at first, but it recently took on a rapid growth, appearing at the time somewhat larger than a pigeon's egg, and adherent to the surrounding tissues. Close under this swelling was a second growth about the size of a bean.

The tumor was situated between the origin of the sterno-mastoid muscle and the ascending ramus of the jaw close under the lobe of the ear; it was adherent to the surrounding structures, especially to the parotid glands, and it penetrated deeply into the retro-maxillary space. The growth was carefully dissected out, sparing as much as possible the nerves, vessels, and muscles. It was found necessary to remove a part of the parotid, as this was involved. Besides the tumor mentioned, nine or ten bean to cherry-sized glands were removed from the region of the angle of the jaw.